



Radio Medical Advice Form - Primary

Datum/Date: ____ . ____ . 20 ____ **Zeit/Time (UTC):** _____

Dringlichkeit (Level of urgency):

Lebensbedrohlich (danger of life) **additionally call +494721 78 5** **nicht-lebensbedrohlich** (routine)

1. Schiffsname (Name of ship)		2. Rufzeichen (Callsign)		3.1 Telefon		4. Lat./Long. N/S	
				3.2 E-mail		W/E	
5. Kapitän (Master)		6. Reederei (Owner)		7.1 Zielhafen (Port of destination)		7.2 ETA	
8. Type of ship		9. Medikamentenliste (Druglist) <input type="checkbox"/> WHO Liste beilegen (please attach list to mail) <input type="checkbox"/> A1/2 <input type="checkbox"/> B <input type="checkbox"/> C1/C2		10.1 Nothafen (Next possible [emergency] port)		10.2 ETA	
11. Patient Name/Nationalität		12. Geschlecht (sex) <input type="checkbox"/> männlich (male) <input type="checkbox"/> weiblich (female)	13. Alter (Age)	13.1 Größe [cm] (height)	13.2 Gewicht (bodyweight) [kg]	14. Tropenaufenthalt (letzte 2 Monate) (visit to tropical area in the last 2 Month) <input type="checkbox"/> nein (No) <input type="checkbox"/> ja, bitte die Aufenthaltsorte als Anlage beifügen (yes, please attach whereabouts)	
16. Basisbefunde (findings)				<input type="checkbox"/> Befunde alle unauffällig (all findings within normal ranges)			
A	16.1 Atmung (Airway/Breathing)	16.1.1 Atemfrequenz (Breaths per Minute) _____/min.	16.1.2 Atmet der Patient normal? (normal breathing?) <input type="checkbox"/> ja (yes) <input type="checkbox"/> nein (no), specify @ 17.1.1		16.1.3 Atemnot? (Dyspnea) <input type="checkbox"/> nein (no) <input type="checkbox"/> ja (yes)		
B	16.2 Herz/Kreislauf (Circulation)	16.2.1 Herzfrequenz (Heart rate) _____/min. 16.2.2 unregelmäßig (arrhythmic beating) <input type="checkbox"/> nein (no) <input type="checkbox"/> ja (yes)	16.2.3 Blutdruck (Blood Pressure) _____ / _____ mmHg		16.2.4 Brustschmerzen (Chest Pain) <input type="checkbox"/> nein (no) <input type="checkbox"/> ja (yes)		
D	16.3 Bewusstsein (Consciousness)	16.3.1 Patient ist (patient reacts to) <input type="checkbox"/> A lert <input type="checkbox"/> V erbal <input type="checkbox"/> P ain <input type="checkbox"/> U responsive		16.3.2 Extremitätenbewegung: (movement of extremities) <input type="checkbox"/> seitengleich (equal on both sides) <input type="checkbox"/> sonstiges: others specify @ 17.1.1			
E	16.4 Externes (Externals)	16.4.1 Hautfarbe (skin appearance) <input type="checkbox"/> normal <input type="checkbox"/> blass (pale) <input type="checkbox"/> schweißig (sweaty) <input type="checkbox"/> specified @17.1.1	16.4.2 Temp. °C oral/axillar/rectal		16.4.3 Verletzungen (injuries) <input type="checkbox"/> nein (No) <input type="checkbox"/> ja (yes), specify @17.1.1		
17. Angaben zum Ereignis/Erkrankung: (Details to incident/disease)							
17.1 S ymptoms							
17.1.1						17.1.2 	
17.2 A llergies							
17.3 M edication (previous)							
17.4 P ast Medical History							
17.5 L ast oral Intake							
17.6 E vents prior to Incident							
18. Verdachtsdiagnose an Bord: (Suspected diagnosis)							

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19. Bisherige Maßnahmen: (Treatment on board)